Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4961AGZ	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7TH HEAVEN	1205 PONCE DE LEON AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility from 5/29/09 - 6/23/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was two. Zero resident files were reviewed and zero employee files were reviewed due to the fact that the files could not be produced. Complaint #NV00021432 was substantiated with deficiencies.	Y 000		
Y 051 SS=C	449.194(2) Administrator's Responsibilities-Designation NAC 449.194 The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the	Y 051		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 051	Continued From page 1 facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. This Regulation is not met as evidenced by: Based on observation and interview on 5/29/09, the administrator failed to designate an employee to be in charge of the facility in her absence. Severity: 1 Scope: 3	Y 051		
Y 085 SS=I	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. This Regulation is not met as evidenced by: Based on observation and interview from 5/29/09 to 6/24/09, the administrator failed to ensure a trained caregiver was on duty at all times for 2 of 2 residents who were in the facility (Resident #1 and #2).	Y 085		

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Y 085	Continued From page 2 Findings include: (See Tag Y590) Resident #3 was removed from the facility on 3/21/09 after her daughter discovered she had developed a pressure ulcer by her tailbone. The family of the resident reported they had concerns about the lack of care their mother was receiving at the facility and that when the operator was gone, she was leaving the resident's in the care of "helpers " that did not speak English or know about their mother's needs. On 5/29/09, an on-site complaint investigation was conducted at the facility. A male person answered the door and reported the owner was not at home. The male stated the owner had gone to California and left him "in charge" of the facility and the care of two residents. A request was made for his personnel file and he stated "I'm just visiting from the Philippines and helping out my Auntie. I don't have a file." He called the owner and this investigator spoke with her on his cell phone. The owner stated that she had an emergency and she had to leave to go to California. The owner was reminded that she could not leave her group home without a qualified caregiver to care for Resident #1 and #2. The owner stated that she would be driving back that evening. The nephew did not have access to any of the resident or employee files which were locked in a hallway closet. Severity: 3 Scope: 3	Y 085		
Y 590 SS=H	449.268(1)(a) Resident Rights NAC 449.268	Y 590		

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Y 590	Continued From page 3 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Based on interviews, record reviews, and observation from 5/29/09 to 6/24/09, the administrator of the facility failed to ensure that 1 of 3 residents was not neglected by staff members resulting in a pressure sore (Discharged Resident #3). Findings include: Resident #3 was admitted to the facility in January 2009. The resident's family reported they had concerns regarding the care the resident been receiving and they had discussed their concerns with the owner of the facility on several occasions. The family reported when they visited the resident, they noticed she was spending a lot of time in her bed and that she was being told by the caregivers to go to her room to lie down. The family stated they were concerned about the facility being dark and cluttered, that there were no activities provided to keep their mother busy, that there was no menu posted and they noticed the residents were being served "fast food burgers" instead of a full meal. Family members also stated they talked to the operator concerning Resident #3's medication and meal schedule and stressed that the resident did better when she received her meals and	Y 590		

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Y 590	Continued From page 4 medications at consistent times of the day. The family noticed during visits that the meal schedule varied depending on who was working and that their mother was not receiving her medications at the times they were prescribed. The family reported that the owner had "helpers" she left in care of the residents when she was out of the facility. The "helpers" did not speak English very well and had a difficult time understanding the family's questions concerning meals being served at odd times of the day and about their mother's medications. (See Tag Y085) The daughter for Resident #3 reported that on 3/21/09, she took her mother out to lunch. She was helping her mother in the restaurant restroom and noticed skin breakdown on the left side of her mother's buttocks. The daughter stated she immediately removed her mother from the facility and moved her into another group home. The daughter took her mother to her physician who ordered home health to care for a pressure ulcer. Home health agency (HHA) documentation showed Resident #3 was examined by Dynamic Home Health on 3/24/09. The admission examination documented that there was a 3cm x 2cm x 0.2cm decubitus ulcer (pressure sore) on the left side of the resident's coccyx, with a small amount of serous sanguinous drainage noted. A sterile dressing with silvadene ointment was applied on a daily bases until the area was healed. The resident continued receiving treatment for the pressure sore from the home health agency until 5/12/09. Severity: 3 Scope: 2	Y 590		